

FMS Foundation Newsletter

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Dear Friends,

"It is probably no news to you that society today has a growing distrust of psychotherapy."

Advertisement for special issue of
Journal of Psychohistory
"Backlash Against Psychotherapy"

If this is so, perhaps it is because the American public is now behaving more as responsible consumers instead of passive bystanders. After all, psychotherapy is an essential service and people who need that service should be assured of quality care.

"Sustained pressure or persuasion by an authority figure could lead to the retrieval or elaboration of memories of events that never actually happened. The possibility of therapists creating in their clients false memories of having been sexually abused in childhood warrants careful consideration, and guidelines for therapists are suggested here to minimize the risk of this happening."

Executive Summary

Report of the British Psychological Society

This is an important point. It affirms the reality of false memories. It is another reason for therapists to follow the June 1994 AMA statement that recovered memories of childhood sexual abuse "should be subject to external verification"

If a new drug were invented that cured some people from a terrible disease but that also maimed and killed others to whom it was given, would it continue to be used? Would the risk be worth it? Consider Thalidomide. How long did it take to remove it from the market after the negative effects were discovered? Indeed, it was never allowed on the American market. Did anyone argue that it should be available until more research was done? Did doctors say, "We don't understand why it is having the bad effect on some people so we'll continue to use it until more research is completed?" Did they say, "The problem only involves a small number of people so it is OK to continue?"

This analogy mimics some of the arguments made by some in the clinical community. It may be this kind of thinking that accounts, in part, for "growing distrust of psychotherapy." "I may be wrong," can be one of the more difficult things for some people to say. It may be especially difficult for therapists in our society to say because they have been given so much authority. Yet, this is what it will take to stop the harm being done by ill-conceived and non-scientific thinking.

Broad public distrust for psychotherapy builds when existing societal mechanisms fail to take the corrective actions that bring therapeutic practice in congruence with science. Consumers first turn to the professional organizations and licensing boards to correct the wrongs they experience. Until recently, these organizations seemed to turn their backs on these legitimate grievances. The slow pace of

these organized bodies in responding to people harmed by therapy only adds to the distrust that people have.

This may be turning around. Originally, only a small handful of therapists were public in their concern about the problems created by the misapplication of knowledge around memory. They are being joined by more of their colleagues. Distrust may ebb as more concerned clinicians speak publicly to their professional organizations, state licensing boards and to the public at large. The Foundation stands ready to help lessen the distrust that people have about psychotherapy.

There are many positive things going on that indicate we are getting closer to a conclusion of the FMS phenomenon. The article by Paul McHugh on page 2 about the cycle of crazes is helpful in terms of seeing just where we are. This is an important perspective for those families who have not had any change in their personal situations. It may help them to understand that each time an accuser reaches out to resume contact, the cycle is moving forward even if it has not yet resulted in personal relief. As the cycle inevitably moves forward, the probability for relief in an individual family increases.

Each time an article appears that presents accurate information, we move forward and are closer to seeing an institutionalization of the scientific view of memory. The 1995 *Information Please Almanac* devotes two full pages to the topic of recovered memories. A new *Abnormal Psychology* textbook by R. Comer (W. H. Freeman & Co, 1995) has two pages about false memories. In addition to on-going articles in mental health journals, newspapers that cater to the legal community have begun to report regularly on the recovered memory cases in a scientific context. Two new books have appeared that add to our understanding of the issues. *Diagnosis for Disaster: The Devastating Truth about False Memory Syndrome and Its Impact on Accusers and Families* by Claudette Wassil-Grimm (Overlook) and *Survivor Psychology: The Dark Side of a Mental Health Mission* by Susan Smith (Upton Books).

Does this mean that there is nothing more to do? On the contrary. Two books about how to treat "survivors" of intergenerational satanic cults have recently crossed our desk. The American Psychological Association has published a book that promotes the use of a symptom check list for diagnosing incest survivors and using hypnosis for finding memories. A high school health class is required to memorize and then take a "true-false" test on Blume's check list of symptoms. There seems a near desperate attempt by critics to try to prove that they are right—so much so that they forget that they put themselves at risk in using techniques or theories that may bring harm. "First, do no harm." Have our critics forgotten this? Each of us, professionals or families, must do everything we can to end this misdirection of clinical thought and to again put our resources where they will help children, victims of abuse and families.

Pamela

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The False Memory Craze

Paul R. McHugh, MD

Henry Phipps Professor and Director, Department of Psychiatry
The Johns Hopkins Medical Institutions

It is easy to believe that the false charges against families of having abused their children years ago will continue unabated. The great difficulty of proving the negative and assembling this proof, years after the event, encourages this pessimistic view. As well, the fact that many professional mental health workers, if not joined into the accusations, seem to retire and take the "balanced view" of the matter is also discouraging. Finally, the increasing numbers of these charges against families and the great publicity the charges receive can provoke the view that we have only begun to discover mistreatment of children that is the cause of a variety of mental disturbances in later life.

Those of us who are calling for standards of psychiatric practice that would examine these charges and, as well, demonstrate the illogic of the argument and the shabbiness of the data on which the argument is based, all of which have been discussed in the pages of the False Memory Syndrome Foundation newsletter, can, however, find some optimism if we recognize that the false memory epidemic is a human phenomenon of crowd behavior. Many of us have commented about the similarity of this situation to the witch trials and to the lynch mobs in which anger and violence against people have been generated without evidence. It is useful to recognize that our social scientists have long since demonstrated that cultures can be swept by a craze for a false idea that takes a very standard course almost predictable in its form.

The best discussion of crazes was written in the 1950s by L.S. Penrose who, in his book, Objective Study of Crowd Behavior, described five different stages that crazes go through, both crazes of an innocuous as well as a dangerous kind.

Phase I - Latent Phase. Penrose defined this initial phase in the craze by stating that the idea which is the source of the problem is found in a few minds, but is not spreading. An example of this in our situation might be the idea that Multiple Personality Disorder was an expression of dissociation and child abuse that Cornelia Wilbur and a few of her associates held in the early 1970s.

Phase II - Explosive Phase. During this phase the idea spreads exponentially within a community of interested people. For example, beginning in the late 1970s and early 80s the idea that repressed memories could include histori-

cal aspects of a person's life spread within much of the mental health community and took on remarkable forms, including beliefs about satanic ritual abuse and even alien abduction. The susceptibility seemed to rest upon the search for some explanation for a variety of mental disorders that are often difficult to treat. The repressed memory concept satisfied this need.

Phase III - Saturation Phase. This phase is characterized by the market of "susceptible" minds in the community becoming saturated and the number of new converts to the idea slackening. It seems to me that we are in this phase with the repressed memory craze. Fewer people seem ready to immediately acquiesce to the idea. This phase, though, is difficult to distinguish from the following phase.

Phase IV - Immunity Phase. This phase is characterized by resistance to the idea developing within the community and enthusiasm weakens for it, even amongst the initially involved. Resistance develops as individuals study the idea and its implications. In our case, the study from many

excellent investigators of the logic behind the concept of "repressed memories" and the shabbiness of the data that generated the ideas and supports it today provokes much of this resistance and, as has been seen by many of the initial proponents, they begin to recognize that their reputation may be damaged if they are not more careful in their advocacy of these ideas. I believe that our situation with false memories could be considered somewhere between the Phase III/Phase IV stages as outlined by Penrose.

Phase V - Stagnant Phase. This phase is characterized by the idea fading away, except perhaps in the minds of a few enthusiasts. This is the place where false memories will be within the next five to ten years. The phase will be generated in part by science, but in part by legal processes in which the malpractices that generated the idea of repressed memories will be demonstrated, and eventually psychotherapeutic practices will be restored to their initial integrity. The important point is that one cannot expect everyone to recover nor all to see the misdirection that the repressed memory idea generated. We must accept the fact that this idea will remain in the minds of some who will become progressively more marginalized in the field of mental health by their support of these views.

I am optimistic that exactly this course is being followed but it carries the implications that we must continue

our efforts to immunize the public and document as best we can this historical moment of grief and misdirection in our field.

The FMS Story: Letters from a daughter

September 1988 "And that's one other thing that I want to thank you for, Mom and Dad. I feel that I have the 'ideal' parents and I'm so privileged to have a beautiful spiritual heritage that you both have given me. There is no better family to live in! I thank God for you both."

July 1990 "When I got out of my first session, I was stunned and totally shocked. My counselor pointed out that my problems may have resulted from being sexually abused as a child... Since that first visit, I have become totally convinced that yes, indeed, I was sexually abused. Due to the horror of those occasions in my childhood, I chose to block out what happened to save myself from the pain. With the help of my therapist and a lot of digging on my own, I've been able to recall a lot from my childhood."

January 1992 "I'm writing to say good-bye to you. It's been a year now since you and I last met and, Dad, it's apparent after this much time just how unwilling you are to be reconciled with me... If you desire reconciliation, please do as I have asked you in the past—see a therapist."

Stop Child Sex Abuse AND Memory Recovery Therapy

D. Stephen Lindsay, Ph.D.

At the recent conference in Baltimore, I summarized highlights from Poole, Lindsay, Memon, and Bull's (in press) surveys of psychotherapists' opinions, practices, and experiences regarding clients' memories of childhood sexual abuse (CSA). I prefaced my report by commenting on the broader cultural context in which the popularity of memory recovery therapies arose. My central argument in those prefatory remarks was that there is no contradiction in being concerned about the reality of CSA while at the same time being concerned about the risks of memory recovery techniques. In making that argument, I stated that even when CSA is defined quite narrowly (e.g., to include only cases of physical sexual contact) the best available evidence indicates that there are millions of people in North America who were victimized in this way as children.

After my talk, I learned that some audience members had found my statements about "millions" of victims confusing. Several people approached me about this, and one said something along the lines of "If there really are millions, maybe therapists who think many of their clients have hidden memories of CSA are right." It occurred to me later that some therapists have made the same mistake that these audience members had made.

What one must keep in mind is that there are some 300 million people in North America. Thus, for example, if we accept Russell's (1983) finding that 5% of women in a large retrospective survey reported actual or attempted contact CSA perpetrated by fathers, then millions of women in North America experienced such abuse as children. This does not mean, however, that a large percentage of psychotherapy clients are likely to have hidden memories of extensive histories of CSA. For one thing, this prevalence estimate includes reports of "attempted" as well as "actual" abuse, and reports of one-time as well as multiple instances; thus although the number of victims is staggeringly large, only a very small percentage of the population has histories of repeated incestuous contact CSA. For another thing, research indicates that few victims of CSA—especially repeated contact abuse that occurred beyond the first few years of life—are likely to forget that it occurred. Thus, even under the assumption that survivors of abuse are more likely to seek therapy than other members of the population, people with recoverable hidden memories would, at most, make up a tiny minority of clients. Furthermore, there is little reason to believe that therapists can discriminate between clients with hidden histories of abuse and clients with no histories of abuse. Finally, there is no evidence to support the notion that attempting to recover such memories helps clients, and ample evidence supports the concern that searches for hidden memories are risky. Thus acknowledgement of the prevalence and importance of CSA should not be construed as support for "therapeutic" searches for hidden memories (although it may help understand why some therapists have promulgated such searches).

The sexual abuse of children is an extremely important problem. People concerned about false memories must continually remind themselves and others that support for victims and survivors of abuse must not be undermined by efforts to stop the use of risky memory recovery therapies. If we are clear about this, there is no contradiction between pursuing these goals simultaneously. Indeed, I would argue that it is only when one has an exclusive focus on detecting survivors of abuse, or an exclusive focus on avoiding false reports of abuse, that unappealing trade-offs become inevitable. I suggest as a slogan for the Foundation: "Stop Child Sexual Abuse AND Stop Memory Recovery Therapies."

Report on the Johns Hopkins/False Memory Syndrome Foundation Meeting, Baltimore, December 9-11, 1994 Colin A. Ross, M.D.

Colin A. Ross, M.D., author of many books and Director of the Dissociative Unit at Charter Hospital in Dallas, Texas, has several times been the subject of disparaging comments in this Newsletter (Vol 2, Nos. 4,5,8). He is often considered to be one of the most prominent advocates of treatment for multiple personality disorder. He has contributed the following communication for the FMS Foundation Newsletter. We are delighted to print it. Responses, as usual, will be welcome.

I am submitting this report simultaneously to the Newsletter of the International Society for the Study of Dissociation (ISSD) and the False Memory Syndrome Foundation (FMSF). As immediate past President of the ISSD, I was concerned that I might receive a hostile reception at the meeting in Baltimore. In fact the response to my presence was warm and cordial, with a few exceptions, and numerous people said that they were glad to see me there, and that the two camps need to begin a conversation—the individuals who expressed this view included accused fathers, re-

"...families can and do survive real incest. But it is very difficult to recover from imagined incest."

Frank Pittman, M.D.
"Ask Dr. Frank" *Psychology Today*
Nov/Dec 1994

canters who have successfully sued their therapists, wives of accused fathers, lawyers who have won false memory suits, psychologists, and psychiatrists.

The social process and dynamics of the Baltimore meeting were identical to those of the multiple personality meetings held in Chicago in the mid to late 1980's. Both meetings were in part expressions of a social cause, with the audience providing standing ovations when stirring orators espoused the group political doctrine. The audience at both meetings was a mixture of survivors, paraprofessionals, and clinicians, and at both meetings victims in the audience could be seen receiving back rubs from significant others. At both meetings the speakers were predominantly male M.D.s and Ph.D.s. There were survivor forums at both meetings, and undisguised cases were presented on stage in Baltimore. Both meetings involved a great deal of belief and insufficient empiricism.

The meetings differed demographically, with an upward age shift in Baltimore, and many more males in the audience in Baltimore. The key difference was a rotation of the

victim-rescuer-perpetrator triangle—both meetings were focused on championing the cause of the victim. In Chicago in 1988 the highest-ranking victim was the female MPD patient whose perpetrator was a male Satanist and rescuer a therapist, while in Baltimore in 1994 the victim was a falsely accused father, the rescuer the lawyer, and the perpetrator the MPD therapist. The demographics of the roles had shifted but the dynamics were identical.

At both meetings the projected bad self was clearly identified—in 1994, ISSD members tend to view the FMSF as “perps incorporated” while FMSF members tend to view the ISSD as “incompetent hysterics of America.” Both these perceptions are based on the sociology of rumor, the psychodynamics of projection, and overgeneralization from biased samples. Many FMSF members, I learned, have attitudes towards me which are based on rumor—this is the inverse of the Satanic panic analyzed by Victor (1993) and Mulhern (1994).

ISSD members tend towards an equation according to which FMSF membership = perpetrator = denial, while FMSF members tend to accept the equation MPD diagnosis = hysteria = false memories = patient and family harm. Many professional FMSF members are below scholarly standard in terms of knowledge of the dissociation literature, while many ISSD members are insufficiently aware of the literatures of the imprecision of memory, demand characteristics, and coercive persuasion. The two organizations are mirror opposites of each other. Both have a lot to teach each other, although in both groups there are ideologically fixed extremists. Both groups tend to be highly critical of the other, but blind to the same logical errors made by themselves.

Many of the Baltimore talks could be given at an ISSD meeting, and be well accepted there. ISSD members need to be aware that there is a wide diversity of viewpoints among speakers at FMSF meetings, as there is in the ISSD—in Baltimore different speakers stated that there is no such thing as repression, espoused classical psychoanalytical theory, described treatment of a retractor based on classical Janetian trauma-dissociation theory, and described a variant of cult exit counseling. Much of the focus was more on standards of practice than memory issues, and I agreed with more than half of what was said.

One of my goals is to convince FMSF members that the key variable of mutual interest should be impaired professionals and bad therapies. According to substantial but not definitive data MPD/DID is a reliable and valid diagnosis according to the DSM-IV system rules. The DSM-IV diagnosis of MPD/DID does not require adherence to a theory of “robust repression,” a reported history of sexual abuse, or belief in any particular mental mechanism or metaphysical construct. This is analogous to panic disorder—establishing that the diagnosis of panic disorder is reliable and valid has nothing to do with Freudian theories of signal anxiety. The DSM system is atheoretical and phenomenological thought, including in the dissociative disorders sec-

tion. The belief that the validity of MPD/DID stands or falls based on theories of repression is simply wrong.

I would like to convince FMSF members that MPD/DID should be disconnected from the problem of bad therapies and impaired therapists. Until 1991 I was a full-time salaried academic in Canada—I saw countless examples of wildly incompetent polypharmacy with major harm to patients, any of which would be grounds for a successful malpractice suit. I’m not convinced that the percentage of impaired clinicians is higher in dissociative disorders field than in biological psychiatry.

It is true that there are impaired therapists practicing in the dissociative disorders field. I believe, based on my clinical experience, that some patients with Satanic ritual abuse memories are suffering from DSM-IV dissociative disorder not otherwise specified resulting from exposure to coercive persuasion and indoctrination in a destructive psychotherapy cult. However, the false memories are only a minor component of the problem clinically. Why? What is really

harming patients and families is generic bad clinical practice, and basic ethical and boundary violations. It is possible to have false memories in a good therapy and no false memories in a bad therapy.

The problem is not the existence of the false memories as such, it is how they are managed and handled in therapy. I think the FMSF has over-attributed the causality of the false memories to therapist variables, and over-attributed the problems in bad therapies to the memories. On the other side many ISSD members have been blind to the

damaging effects of their failure to maintain therapeutic neutrality with regard to the reality of the memories.

The primary error of FMSF members is that, since someone has to be bad, the family can only achieve reconciliation if it is the therapist who caused the problems.

The primary error of ISSD members is that the FMSF crowd are only interested in protecting perpetrators. This simply isn’t true. Both groups overgeneralize from subsamples within the opposing population. My motive for going to the Baltimore meeting was in part my knowledge that meeting someone face-to-face is a powerful counter to projection of badness. It is time that psychiatrists and psychologists in both camps sought a common ground, and took an empirical and scientific approach to complex problems. The mental health field suffers from MPD/DID—the ISSD and FMSF are “alters” within a larger system who are refusing to talk to each other or inhabit the same body. This does not work inside individuals, nor does in work in the mental health field.

Mulhern, S. (1994). Satanism, ritual abuse, and multiple personality disorder: a sociohistorical perspective. *International Journal of Clinical and Experimental Hypnosis*, 42: 265-288

Victor, J.S. (1993). *Satanic Panic. The Creation of a Contemporary Legend*. Chicago: Open Court.

Another problem in understanding who is receiving psychotherapy is that there is still no agreed-upon definition of psychotherapy. Consequently, when a person makes a visit to a mental health specialist, it is still hard to know just what treatment that person is receiving.

John Vessey & Kenneth Howard
“Who Seeks Psychotherapy?”
Psychotherapy 30 (4) 546-553

NEW BOOK

The American Psychological Association had recently published a book with the subtitle "A practical guide for the psychotherapist" that suggests using hypnosis to recover memories. Although published by the APA its author is not the Association but Lenore E.A. Walker, Ph.D. Until recently Dr. Walker has been most famous as the inventor of the Battered-Woman Syndrome. (We say "until recently" because her presence as an O.J. Simpson defense witness has become a matter of much comment.) Her new book comes with a foreword by Laura S. Brown, Ph.D. (member of the APA's task force on recovered memories). Dr. Walker's book, whose full title is "Abused Women and Survivor Therapy: A practical guide for the psychotherapist" does indeed include a section on hypnosis and it reports with apparent approval that "Hypnosis is often used as an adjunct to verbal therapy in order to gain access to buried memories, particularly buried memories of incest and other early abuse." (p.425)

Earlier in the book (p.85) Dr. Walker asks about people such as Elizabeth Loftus, "Why would adult memory researchers contradict the clinical findings?" (She answers—it is amusing to note—that among the things that "may figure into such motivation" is the "enjoyment of the recognition provided by groups that rally around men who are allegedly falsely accused.") And what are the clinical findings? Immediately preceding is a paragraph describing Linda Meyer Williams's frequently cited study. Unfortunately, Dr. Walker can make many errors in her 343 words describing this study. We'll mention just a few of them: She misreports the number of subjects; she inflates by a factor of three the percent of subjects that "did not report any sexual abuse had occurred during their childhood" (the actual percentage was 12%; 38% failed to report the index event); she claims that "Most of these women appeared to be amnesic for such abuse," (a claim Williams carefully refrained from making).

But most disturbing in this APA publication is its endorsement of check-lists. On page 113 we read:

The importance of sorting out the most accurate diagnosis lies in the acceptance of treatment by victims and survivors and in appropriate treatment planning. Blume (1989) listed more than 30 common symptoms of what she called "postincest survivor syndrome" in her check-list.

Dr. Walker then gives her own version of the Blume list. On the left below is the original Blume list with its original numbers. On the right is the Walker list (to which we've added the numbers). There are some remarkable differences. There are also similarities. Neither checklist includes information about the reliability, validation, standardization or outcome studies for their use.

Blume's List

1. Fear of being alone in the dark; sleeping alone; nightmares, night terrors (especially of pursuit, threat, entrapment);
2. Swallowing and gagging sen-

Walker's List

- 1) fears of being alone, particularly at night;
- 2) swallowing and gagging re-

sitivity; repugnance to water on one's face when bathing or swimming (suffocation feeling).

3. Alienation from the body—not at home in own body; failure to heed body signals or take care of one's body; poor body image; manipulation of body size to avoid sexual attention.

4. Gastrointestinal problems; gynecological disorders (including spontaneous vaginal infections); headaches; arthritis or joint pain.

5. Wearing a lot of clothing, even in summer; baggy clothes; failure to remove clothing even when appropriate to do so (while swimming, bathing, sleeping); extreme requirement for privacy when using bathroom.

6. Eating disorders, drug or alcohol abuse (or total abstinence); other addictions; compulsive behaviors.

7. Self-destructiveness; skin carving, self-abuse.

8. Phobias.

9. Need to be invisible, perfect or perfectly bad.

10. Suicidal thoughts, attempts, obsession (including "passive suicide").

11. Depression (sometimes paralyzing); seemingly baseless crying.

12. Anger issues: inability to recognize, own, or express anger, fear of actual or imagined rage; constant anger; intense hostility toward entire gender or ethnic group of the perpetrator.

13. Splitting (depersonalization); going into shock, shutdown in crisis; psychic numbing; physical pain or numbness associated with a particular memory emotion (e.g., anger), or situation (e.g., sex).

14. Rigid control of one's thought process; humorlessness or extreme solemnity.

15. Childhood hiding, hanging on, cowering in corner (security-seeking behaviors); adult nervousness over being watched or surprised; feeling watched; startle response.

16. Trust issues: inability to trust (trust is not safe); total trust; trusting indiscriminately.

17. High risk taking ("daring the fates"); inability to take risks.

18. Boundary issues; control power, territoriality issues; fear of losing control; obsessive/compulsive behaviors (attempts to control things that don't matter, just to control something).

19. Guilt, shame; low self-esteem, feeling worthless; high appreciation of small favors by others.

reflex sensitivity and problems with feelings of suffocation, especially when water gets on one's face;

3) poor body image;

4) covering one's body with lots of loose clothing;

5) extreme privacy needs in the bathroom or bedroom;

6) eating or substance abuse disorders;

7) cutting one's skin and other self-destructive behaviors;

8) phobias;

9) need for invisibility or exhibitionism;

10) suicide ideation and attempts;

11) obsessive rumination;

12) anger and rage issues;

13) depersonalization and other forms of pain or numbness;

14) no sense of humor or constant wisecracking;

15) intense anxiety and fears as a child;

17) inability to trust or indiscriminate trust;

16) high risk taking or inability to take risks;

18) fear of losing control and need for intense control;

27) great appreciation of small favors by others;

20. Pattern of being a victim (victimizing oneself after being victimized by others), especially sexually; no sense of own power or right to set limits or say no; pattern of relationships with much older persons (onset in adolescence).
21. Feeling demand to "produce and be loved"; instinctively knowing and doing what the other person needs or wants; relationships mean big tradeoffs (love was taken, not given).
22. Abandonment issues.
23. Blocking out some period of years (especially 1-12), or a specific person or place.
24. Feeling of carrying an awful secret; urge to tell, fear of its being revealed; certainty that no one will listen; being generally secretive; feeling "marked" ("the scarlet letter").
25. Feeling crazy; feeling different; feeling oneself to be unreal and everyone else to be real, or vice versa; creating fantasy worlds, relationships, or identities (especially for women; imagining or wishing self to be male, i.e., not a victim).
26. Denial: no awareness at all; repression of memories; pretending; minimizing ("it wasn't that bad"); having dreams or memories ("maybe it's my imagination"); strong deep, "inappropriate" negative reactions to person, place or event; "sensory flashes" (a light, a place, a physical feeling) without a sense of their meaning; remembering the surroundings but not the event.
27. Sexual issues; sex feels "dirty"; aversion to being touched, especially in gynecological exam; strong aversion to (or need for) particular sex acts; feeling betrayed by one's body; trouble integrating sexuality and emotionality; confusion or overlapping of affection, sex dominance, aggression, and violence; having to pursue power in sexual arena which is actually sexual acting out (self-abuse and manipulation, especially among women; abuse of others, especially among men); compulsively "seductive" or compulsively asexual; must be sexual aggressor or cannot be; impersonal, "promiscuous" sex with strangers concurrent with inability to have sex in intimate relationship (conflict between sex and caring); prostitute, stripper, "sex symbol," porn actress; sexual acting out to meet anger or revenge needs; "sex-aholism"; avoidance; shutdown; crying after orgasm; all pursuit feels like violation; sexualizing of meaningful relationships; erotic response to abuse or anger, sexual fantasies of dominance or rape (Note: Homosexuality is not an aftereffect).
28. Pattern of ambivalent or tensely conflictive relationships (intimacy is a problem; also focus shifted from incest issue).
29. Avoidance of mirrors (connected with invisibility, shame/self-esteem issues, distrust of perceived body image).
30. Desire to change one's name (to disassociate from the perpetrator or to take control through self-labeling).
31. Limited tolerance for happiness; active withdrawal from happiness, reluctance to trust happiness ("ice-thin").
32. Aversion to making noise (including during sex, crying, laughing, or other body function); verbal hypervigilance (careful monitoring of one's words); quiet-voiced, especially when needing to be heard.
33. Stealing (adults); starting fires (children).
34. Multiple personality.
- 19) multiple victimization experiences;
- 21) relationships demanding unconditional love;
- 22) extreme need to please others;
- 20) abandonment issues;
- 24) blocking out early childhood years;
- 23) ambivalent or conflict ridden relationships;
- 28) frequency of certain behaviors such as stealing, firesetting, and avoidance of mirrors [also appears beside 33].
- 25) limited tolerance for happiness and other limited range of emotions;
- 26) quiet-voiced;
- 28) frequency of certain behaviors such as stealing, fire-setting, and avoidance of mirrors [also appears beside 29].

CORRECTION

We said last September that David Calof of Seattle, Washington, had no known credentials. He asked us to list the following as his credentials: he is an RMHC (Registered Mental Health Counselor) in the State of Washington, he is a Visiting Faculty Member of the San Francisco Family Institute, and he is a Senior Consultant, Psychology Training Center, Seattle Mental Health Institute.

What are credentials? Chuck Noah, also of Seattle is a retired construction worker who recently applied for and received an RMHC credential. Like the other 13,000 people who have been given RMHC credentials by the State of Washington it cost him \$78.50 and he was required to take a 4-hour AIDS course.

REPORT OF BRITISH PSYCHOLOGICAL SOCIETY

In January, the British Psychological Society issued the report on which it has been working for the past 18 months. We urge readers to obtain the full report as it is a testament to the thinking and compromises by clinicians and scientists on the issue of recovered memories. We print the Executive Summary and Guidelines for Therapists. To obtain the full copy, enclose a cheque for \$20 (twenty dollars). British Psychological Society, St. Andrew House, 48, Princess Road East, Leicester LE1 7DR, United Kingdom. The report will be sent by return airmail.

Recovered Memories:

The report of the Working Party of the British Psychological Society
January 12, 1995
Executive Summary

The working party was charged with reporting on the scientific evidence relevant to the current debate concerning Recovered Memories of Trauma and with commenting on the issues surrounding this topic.

We have reviewed the scientific literature, carried out a survey of relevant members of the British Psychological Society, and scrutinized the records of the British False Memory Society. On this basis we came to the following conclusions:

- Complete or partial memory loss is a frequently reported consequence of experiencing certain kinds of psychological traumas including childhood sexual abuse. These memories are sometimes fully or partially recovered after a gap of many years.

- Memories may be recovered within or independent of therapy. Memory recovery is reported by highly experienced and well qualified therapists who are well aware of the dangers of inappropriate suggestion and interpretation.

- In general, the clarity and detail of event memories depends on a number of factors, including the age at which the event occurred. Although clear memories are likely to be broadly accurate, they may contain significant errors. It seems likely that recovered memories have the same properties.

- Sustained pressure or persuasion by an authority figure could lead to the retrieval or elaboration of memories of events that never actually happened. The possibility of therapists creating in their clients false memories of having been sexually abused in childhood warrants careful consideration, and guidelines for therapists are suggested here to minimize the risk of this happening. There is no reliable evidence at present that this is a widespread phenomenon in the UK.

- In a recent review of the literature on recovered memories, Lindsay and Read commented that "the ground for debate has shifted from the question of the possibility of therapy-induced false beliefs to the question of the prevalence of therapy-induced false beliefs". We agree with this comment but add to it that the ground for debate has also shifted from the question of the possibility of recovery of memory from total amnesia to the question of the prevalence of recovery of memory from total amnesia.

Guidelines for therapists

The following guidelines are intended to apply to a range of psychological therapies.

1. It may be necessary clinically for the therapist to be open to the emergence of memories of trauma which are not immediately available to the client's consciousness.
2. It is important for the therapist to be alert to the dangers of suggestion.
3. While it is important always to take the client seriously, the therapist should avoid drawing premature conclusions about the truth of a recovered memory.
4. The therapist needs to tolerate uncertainty and ambiguity regarding the client's early experience.
5. Whilst it may be part of the therapists' work to help their clients to think about their early experiences, they should avoid imposing their own conclusions about what took place in childhood.
6. The therapist should be alert to a range of possibilities, for example that a recovered memory may be literally true, metaphorically true or may derive from fantasy or dream material.
7. If the role of the professional is to obtain evidence that is reliable in forensic terms, they need to restrict themselves to procedures that enhance reliability (e.g. use of the Cognitive Interview and avoidance of hypnosis or suggestion and leading questions).

8. CSA should not be diagnosed on the basis of presenting symptoms such as eating disorder alone. There is a high probability of false positives, as there are other possible explanations for psychological problems.

Overall Conclusions

- Normal event memory is largely accurate but may contain distortions and elaborations.

- With certain exceptions,

such as where there has been extensive rehearsal of an imagined event, the source of our memories is generally perceived accurately.

- Nothing can be recalled accurately from before the first birthday and little from before the second. Poor memory from before the 4th birthday is normal.

- Forgetting of certain kinds of trauma is often reported, although the nature of the mechanism or mechanisms involved remains unclear.

While there is a great deal of evidence for incorrect memories, there is currently much less evidence on the creating of false memories.

- Hypnosis makes memory more confident and less reliable. It can also be used to create amnesia for events.

- There are a number of significant differences between false confessions and false (recovered) memories which preclude generalizing from one to the other.

One welcomed the decision of the BPS to set up a Working Party to report on the widely debated question of "Recovered Memories." Indeed, given the deep clinical and social importance of the question it was prudent for it to do so. In the event, unfortunately, the Report of the Working Party is deeply disappointing and, at its most crucial junctures, is badly flawed. It has helpfully issued a short list of some sensible guidelines for therapists. But its "preliminary survey" of BPS accredited therapists, itself incompletely reported, and its analysis of the problem and its treatment of evidence will do little to redress anxieties that have been widely expressed about particular clinical practices.

Professor L. Weiskrantz
Emeritus Professor of Psychology

- There are high levels of belief in the essential accuracy of recovered memories of child sexual abuse among qualified psychologists. These beliefs appear to be fueled by the high levels of experience of recovered memories both for CSA and for non-CSA traumatic events. The non-doctrinaire nature of these beliefs is indicated by the high level of acceptance of the possibility of false memories.

- There is not a lot of evidence that accusers fit a single profile. From the British records, at least, there is no good evidence that accusers have invariably recovered memories from total amnesia. Further documentation of the phenomenon is needed by the False Memory societies in order to obtain a more reliable picture. It appears that only in a small minority of instances do the accusations concern abuse that ended before the age of five.

- Guidelines can be laid down for good practice in therapy.

The members of the Working Party were: **John Morton** - MRC Cognitive Development Unit, London (chair); **Bernice Andrews** - Royal Holloway University of London; **Debra Bekerian** - MRC Applied Psychology Unit, Cambridge; **Chris Brewin** - Royal Holloway University of London; **Graham Davies** - Leicester University; **Phil Mollon** - Dept of Psychiatry, Lister Hospital, Stevenage.

TWO NEW BOOKS ON SATANIC ABUSE

Safe Passage to Healing: a Guide for Survivors of Ritual Abuse, by Chrystine Oksana, HarperCollins, 1994.

By starting the book with her own story, the author documents the therapeutic practices that led her into spending the rest of her life as a ritual abuse survivor. It is a painful process. The key passage begins on page xxi: "Although my therapy work took nine years, the majority of my healing took place in two and a half years, once I found a therapist who could move me confidently through recovery. Every time I asked 'Do you believe me?' she always answered 'Yes!'" She goes on to say that she had finally found a therapist who "believed me unreservedly." The body of the book is a step by step guide for gaining your own memories, your own alters, your own circle of fellow survivors, finally, your own life as a Survivor of Ritual Abuse. (Sample advice: "work only with a therapist

who believes that ritual abuse exists and that your memories are valid." p.268) This book will stand forever as evidence of just how much damage today's psychotherapy can accomplish.

Treatomg Survivors of Satanic Abuse
Edited by Valeri Simson
Routledge, 1994

Chapter 15 of this book is written by Phil Mollon, a member of the committee that produced the British Psychological Society report on recovered memories. Clinical Illustration 2: Mary is revealing. At the beginning of therapy she had no relevant memories and idealised her parents. She had a drug-assisted abreaction. "Disclosures of flashback memories have very often been followed by suicidal urges, and I believe this may be typical of ritually abused patients." Need we say more?

INSTITUTIONALIZING SRA

The government of Ontario, Canada continues to fund groups devoted to propagating belief in satanic ritual abuse in spite of the complete lack of evidence for such acts (Lanning, 1992, LaFontaine, 1994, and Goodman et al 1994).

In November, the Ontario health ministry gave \$3,876 for a two-day women-only conference at which participants were instructed that they must not wear all black, white or red, or wear stripes or religious symbols. Lawyers, therapists and abuse survivors attended the conference and discussed how to root out memories of being abused by satanists and others and how to get the legal system to accept the allegations. The title of the conference was "Fighting the False Memory Backlash." (Tracey Tyler, Toronto Star, December 22, 1994)

Donna Laframboise reports that the Thunder Bay conference that we described in the January 1995 newsletter has received \$10,000 from the Ontario Women's Directorate through the office of Marion Boyd, the minister responsible for women's issues, and \$5,000 more from the Ministry of Northern Development and Mines' family violence prevention initiative to put on that event. This is the conference that promises to address Masonic ritual torture in Canada. (Toronto Star, Jan 9, 1995).

From an interview on radio station CBQ, CBC affiliate in Thunder Bay, Ontario, 26 January

Most of those memories involved really horrendous kind of accounts, child sacrifice, fairly intense...sexual deviations, a lot of emotional and psychological abuse and so on....The role of alleged Masonry in these accounts varies from account to account. Some of the accounts, however, seem to have taken place in buildings which sound like they were Lodges. Moreover, a lot of these accounts involve group abuse and some people have very strong suspicions that the network in which their, in most cases, fathers allegedly moved were Masonic networks. So a lot of people believe that other alleged abusers were also Freemasons....I do not get other accounts about semi-secret male philanthropic organizations. That is to say I do not get similar kinds of accounts about the Optimist Club or the Rotarians or the Knights of Columbus and so on....people could be drawn into this kind of behaviour because of what they would consider to be a secret tradition within Freemasonry, a tradition that would bring them worldly power by veneration of a particular deviant god and performing rites and rituals to that deviant god.... there's nothing in any of the in-depth normal Masonic literature that I've seen or read or heard about that would give any intentional validity to the kinds of extreme abuse that I've heard. And yet, I still have to come back to the point that the Masons are the only male, philanthropic, semi-secret organization about which I've received accounts along these lines.

Dr. Stephen Kent., Dept of Sociology, U of Alberta.

Research Note Evan Harrington

Recently there has been much debate about the results of a paper which is without doubt one of the most important yet on the topic of adult recall of childhood sexual abuse. The paper is by Dr. Linda Meyer Williams of the Family Research Laboratory of the University of New Hampshire and has just recently been published in the *Journal of Consulting and Clinical Psychology* (Williams, 1994). Professionals in the field have been debating over the meaning of the results of this paper and those who attended the recent FMS conference in Baltimore had the opportunity to listen to both Dr. Williams and some of those who disagreed over what the findings meant. Dr. Williams is praise-worthy for sharing her results at the conference.

Dr. Williams followed into adulthood a group of female children admitted to a hospital emergency ward (seventeen years earlier) by their parents ostensibly because the children had been sexually abused. When interviewed as adults 38% of these women did not report the hospital visits they underwent as children. Some reported other instances of abuse but not the case for which they were admitted to the hospital. Various measures were assessed and tested across those women who reported knowledge of the event ("recall") and those who did not report knowledge of the event ("no recall"). These variables included age, degree of force used, severity of penetration, and closeness to perpetrator.

Most discussion of this paper centers on why some women were apparently unable to recall their abuse. Age was the single best predictor of recall such that younger children had less recall (but some women who were very young at the time still had recall and some who were older when the abuse occurred had "no recall"). The possibility exists that some of the women simply refused to report that they were abused even though they might have recalled it (Pope & Hudson, in press). Other reasons that might account for failure to report the event and the implications of non-recall are discussed in a paper (Lof-tus, Garry, & Feldman, 1994) immediately following the Williams article in the *Journal of Consulting and Clinical*

Psychology. Rather than review these discussions I would like to point out a couple of items concerning the reporting of statistics by Williams (1994) in the hope that this will help clarify the data.

It appears that there is a typographical error which might confuse readers. Dr. Williams at one point writes: "There is a tendency for women who were subjected to more force to *not* recall the abuse," (p. 1172, italics added). That this statement is in error has been confirmed by Dr. Williams. The tendency is that as force increases recall also increases. The data indicating this trend are in table 2, which is a table of the *t* tests. Table two is problematic. The tests are apparently one-tailed, though the table does not note this. It is proper procedure to note the use of one-tailed *t* tests and to provide justification for why such tests were used instead of two-tailed tests. Usually, when a researcher uses a one-tailed *t*, a prediction is stated such that the results of the tests are expected to be in the predicted direction. Neither justification nor prediction were supplied. The actual *t* values were not reported in this table, as is also the custom. Finally, if a one-tailed *t* test is run and the results are in the

opposite direction from the prediction, the *p* values get closer to 1 the larger the *t* gets, whereas a two-tailed *t* will have the same *p* value regardless of the direction of the test. For example, if Dr. Williams had a two-tailed *t* test with $t = 1.98$ ($df = 100$) the *p* value would be the same ($p = .05$) regardless of whether the 1.98 was positive or negative. In a one-tailed test the *p* value will only be .05 if the result is in the predicted direction so that a finding of $t = -1.66$ ($df = 100$) will be $p = .95$ rather than .05. So, if Dr. Williams intended to do a one-tailed test (which is unknown) the *p* value reported in Table 2 for force should be $p = .941$ rather than .059 as is reported. If Dr. Williams did not intend to report one-tailed *t* tests then all of the *p* values in this table are in error and should be transformed to the more conservative values associated with two-tailed tests.

This may seem very arcane, and indeed this material would only really be important for researchers who are sticklers for detail (having the *t* values, noting the use of a one-tailed test, etc.) except for the fact that the Publication Manual of the American Psychological Association is ex-

Question:

Are there really true memories? If you go back far enough back into childhood, how much of your memory is true? Can you trust your memory?

Answer:

I place a lot less trust in my memory than I used to. But you can't go through life not trusting your memory to a great extent. Our memories must be reasonably good or we would not be here. In fact, we can all see how good our memories are if we compare ourselves to brain-damaged people with spectacular memory failures, referred to as organic amnesia. Amnesic patients lose the ability to remember new events and must live in supervised settings.

I have trouble believing the repressed memory business in general. To my knowledge there is no direct evidence for it. I couldn't point you to one solid piece of laboratory evidence for repressed memory. The whole idea flies in the face of two basic facts I know to be true about memory.

One is that we typically have excellent memories for powerful emotional events, even negative ones. In many cases, child abuse victims are obsessed with their memories. They can't get them out of their minds. And we usually have good memories for traumatic events in our lives even when they are quite painful.

Yet those who believe in repressed memories say that "if a terrible event only happened to you once it is very memorable, but if it happens repeatedly then it gets repressed." Well, a second fact that we know about memory is that repeated events are generally much better remembered than events that only happen to you once. So, the whole claim of these repressed memory cases flies in the face of what I know about how memory works."

Henry Roediger, *Rice News*, April 21, 1994
"Issues and Answers/Repressed Memory"

licit about the reporting of such information (American Psychological Association, 1994, pp. 15-16):

Statistical Presentation. When reporting inferential statistics (e.g., *t* tests, *F* tests, and chi-square), include information about the obtained magnitude or value of the test, the degrees of freedom, the probability level, and the direction of the effect. Be sure to include descriptive statistics (e.g., means or medians); where means are reported, always include an associated measure of variability, such as standard deviations, variances, or mean square errors....If there is a question about the appropriateness of a particular test...be sure to justify the use of that test.

Additionally, the relationship of force on recall may be important to different researchers for different reasons and so it is very important that this data is reported accurately. Dr. Williams was most interested in demonstrating that some women will not recall documented cases of abuse from their childhoods. She then assessed several variables to see which would be the best predictors of lack of recall. Other researchers may have different specific hypotheses which these data could either support or fail to support and having accurate reporting of data would be crucial for such researchers. Thus, proper reporting of the data in Table 2 is important and the way it is presented could be clearer.

It is felt by this writer that one prediction made by trauma theory would be that as force goes up recall should go down, thus giving support for the theory of repression of traumatic memory. Any other state of affairs would be a failure to support a hypothesis generated by the theory of repression. The data for force do not indicate that as force goes up recall goes down, thus this writer feels that the data fail to support such an hypothesis. An argument may be made that Lenore Terr's (1991, 1994) Type I (single event) and Type II (multiple event) trauma may play a role in increasing or decreasing recall and that this variability may have a confounding effect on the force-recall relationship. Dr. Williams, with the limited data that were available regarding multiple abusive events, ran a test of those identified as Type I and Type II to see if they had differing amounts of recall. There was no significant difference between amount of recall for those who were identified as Type I and II. Indeed, as Loftus and colleagues (1994) note, those who were known to have experienced repeated abusive events had slightly higher (nonsignificant) rates of recall, which is in the opposite direction as that predicted by Terr's (1991) theory. However, the possibility that differing rates of recall for Type I and Type II trauma may have confounded the effect of force on reduced recall should not be completely ruled out. Future designs of this nature should attempt to test separate hypotheses on Type I and Type II trauma victims. Barring the possibility of confounding by this factor it is felt by this writer that the results of the *t* test on the effect of force on recall fail to support the theory of repression. If the theory of repression would generate the hypothesis that increased use of force should result in decreased recall then the trend shown in the data (like that for Type I and II trauma) is in the opposite direction.

It is hoped that the present discussion of the statistics re-

ported in Table 2 of the paper by Dr. Williams will aid those researchers who need to extract information from this table. It is also hoped that the present discussion of the effect of force on recall will aid those who are casually reviewing the paper. Dr. Williams has undertaken a difficult task and has provided a wealth of information which will be meaningful for researchers for years to come. The critical attention bestowed upon this paper speaks much of its importance.

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MEMORY RECOVERY THERAPY: A SUBCULTURE OF THERAPY CULTS

John Hochman, M.D.

There are three forces, the only three forces capable of conquering and enslaving forever the conscience of these weak rebels in the interests of their own happiness. They are: the miracle, the mystery, and authority.

--F. Dostoyevsky
The Brothers Karamazov,
Chapter. "The Grand Inquisitor"

I became involved with the False Memory Syndrome Foundation through my continuing researches into cults. As more retractors appear, I am seeing similarities that they share with former cult members. But they weren't in cults. Or were they?

Dictionary definitions of cults are inadequate, so I came up with my own, based on my empirical observations of many groups with disparate ideologies. Some groups were inspired by the Bible, some by Hindu scriptures, some by New Age philosophies, some by political doctrines . . .

and some by psychological theories. However, former members of all these groups find they shared much in common.

We think of cults as having definable leaders, who preside over a clear chain of command. Some leaders are public figures and some are only known to cult members. Memory recovery therapy (MRT), by contrast, seems to be more of a social movement or subculture led indirectly by "culture heroes" through their writings and lectures.

However, I see MRT subculture as having produced not one, but thousands of cult leaders: individual therapists, all presiding over their own patients in a vast conglomeration of mini-cults, reinforced by the MRT subculture of books and survivor meetings. Compare it, please, to a coral reef, which seems like a single organism, but is a conglomeration of thousands of single-celled organisms.

MRT, like all cults, promises salvation--the psychological variety. It introduces antidotes to boredom-- noble and sweeping goals to make society a better place by keeping perpetrators at bay and stamping out child abuse. Instead of existential anxiety it offers simple answers and structure--all personal problems are due to childhood molestation, and solved by finding the memories of same. Instead of alienation, patients meet a community of fellow survivors. Instead of impotence--patients strike out against "perpetrators" and even a vast "Satanic Cult."

Cults sprout up when traditional values and structures of a society crumble. The 1960's spawned a counterculture that romanticized drug usage, revolution in general (the sexual revolution in particular) and retreat to communes. As baby boomers entered their teens, America's fertility rate plummeted, while the rate of divorces and adolescent suicides began to climb. During the 1980s the counterculture went mainstream: Drug use continued unromanticized, now at the high school level. The sexual revolution became legitimized through legislation and "safe sex" education. People lost interest in family, marrying less and later, cohabiting more outside marriage, and having increased out of wedlock births.

In the midst of moral chaos, cults fill the breach and offer their own absolutist moralities, which are ultimately self-serving. MRT takes "family values" and turns them on their heads. The family, rather than being a harbor of safety and security, is dangerous and filled with perpetrators; despair not, since a "safe place" is no further than your therapist's office. Therapists, while taking increasing control of their patients' lives, teach them that it was their family that made them powerless. Forget love, think "empowerment." Identity questions are cleared up by the drama of becoming a "survivor."

Cults and Thought Reform: Definitions

Cults are groups using thought reform to recruit and control members, by employing:

a) Miracle: ideology imputing miraculous power to leaders and/or activities.

b) Mystery: secrecy obscuring actual beliefs and practices.

c) Authority: claims on members' time, talents, bodies or property to meet group needs.

Thought reform is a hyper-efficient indoctrination achieved when secrecy impairs indoctrinees' awareness of what is happening to them and what they are becoming; thus, there is no full informed consent. Brainwashing or mind control are popular terms for thought reform.

Miracle, Mystery and Authority in Contemporary Cults

Miracle. The suspension of "natural" and "ordinary" routines, to produce an atmosphere of awe, is implicit in the ideology of every cult. In MRT, therapists have found a miracle therapy based on unfailing theories: after all, if the patient gets worse, don't worry about the theory being wrong--just keep digging for more repressed memories.

Sometimes therapists will introduce "proven" methods to counteract the stupefying "brainwashing" of (nonexistent) Satanic Ritual Abuse.

Mystery. Cults typically use deception in recruiting, which hides undesirable aspects of cult routine. Recruitment into MRT is done by therapists and/or hospital units, and occurs without informed consent. Patients anticipate "recovery" or "healing" and generally have no idea that their lives will

"But as records of courts and justice are admissible, it can easily be proved that powerful and malevolent magicians once existed and were a scourge to mankind. The evidence (including confession) upon which certain women were convicted of witchcraft and executed was without a flaw; it is still unimpeachable. The judges' decisions based on it were sound in logic and in law. Nothing in any existing court was ever more thoroughly proved than the charges of witchcraft and sorcery for which so many suffered death. If there were no witches, human testimony and human reason are alike destitute of value."

Ambrose Bierce, "The Devil's Dictionary"

probably devolve into chaos as they ignore daily life demands to concentrate on their therapy. They are unaware that their treatments may run for years. If patients knew from their first session that MRT would entail risks of destroying their family life as they know it, result in prolonged psychiatric hospitalizations, and possibly involve them in lawsuits against "perpetrators" that they would be likely to lose, then MRT would vanish.

Authority. This is maintained by individual MRT therapists and heads of "dissociative disorder units" in psychiatric hospitals. They have abandoned traditional practices of "therapeutic neutrality" in which patients were encouraged to make adult decisions, replacing them with active encouragement to conform to the values of the MRT subculture. Once therapists undermine relationships with relatives, "orphaned" patients may become increasingly dependent upon them, which further increases the perceived authority of the therapist. This explains why some retractors are telling stories of therapists becoming increasingly maniacal as therapies progressed. Survivor groups maintain social pressures, where questioning of group assumptions can lead to banishment from what becomes a crucial social support.

Future Trends.

MRT advocates are finding themselves increasingly obliged to defend their ideas. Rather than ponder that they might be presiding over a pseudoscience, some have turned

to personal attacks against critics, often outlandish ones. This is a frequent tactic of cults, but they do not have a monopoly on these methods.

As the number of retractors increases, I expect a cascade effect encouraging more retractors. Meanwhile, MRT advocates and "survivors" who see their ranks dwindling may raise the tenor of their attacks on their critics and adopt increasingly bizarre practices. Reactions of other MRT therapists will include retraction, backpedaling, and possibly suicide attempts in some extreme cases.

Since cults see themselves as the guardians of the ultimate truth, they need candidates for Siberia when things go sour. Psychiatrist Robert Lifton, in his studies of brainwashing in Communist China, called this "Doctrine over Person." MRT finds a unique solution to this problem. Cult members who experience suffering learn that their suffering shows they have failed to properly follow cult doctrines. However, when MRT patients do not recover, "perpetrators" get the blame.

Cults often have doctrines that neutralize criticisms of cult members by relatives, describing them as Satanic "suppressive persons," etc. While relatives can generally redeem themselves by approving of the cult member's activities, redemption is impossible for accused relatives of MRT patients. MRT therapists often go beyond labeling family members as "perpetrators" who are "in denial" and encourage their patients to actively wreck relationships with relatives. All of this leaves retractors from MRT with unique burdens of guilt with which they are now struggling to come to terms.

This article is based on a more extended paper discussing the general nature of cults. If you wish a copy of that article, you can contact me at 6345 Balboa, Ste. 255, Encino CA 91316

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Copyright 1994 Guardian Newspapers Limited
September 10, 1994, Pg. T13
By Catherine Bennett
The Satanic Verses

No evidence of satanic abuse has been uncovered in Britain. But still the victims of this invisible epidemic clamour to be heard. And still the experts listen. Should we be mounting a witch-hunt? Or seeking a more realistic way of treating some very damaged people?

Dr Phil Mollon, a consultant clinical psychologist and psychotherapist, mentions a baby sucking at a bottle of blood. When I asked him how the congealing process could allow bottle feeding, he said: 'Yes, there are all sorts of questions of practicalities in these things that crop up.' Could he not have been deluded? 'I accept it's always a possibility,' he said. 'But it's a risk I have to take.'

Dr. Phil Mollon is a member of the British Psychological Society committee that produced the Report on Recovered Memories

child abuse cases, especially when those statements offered to rebut defense allegations that the accusing witness was motivated or influenced to lie. (*Tome v United States*, No. 93-6892 (U.S. Supreme Court, Argued October 5, 1994, Decided January 10, 1995)).

When a child makes an accusation of sexual abuse, it is common for defense lawyers to contend that the child was improperly influenced by police officers, social workers or other adults. Prosecutors in order to rebut those allegations then summon witnesses to testify that the child made similar statements to them.

The court majority found that out-of-court statements made prior to the alleged fabrication of a motive to lie would have been "a square rebuttal of the charge that the testimony was contrived." Statements made afterward, however, shed only "minimal light" on whether the witness was motivated to lie. The majority held that under Federal rule of Evidence 801(d)(1)(B) hearsay statements made after the alleged introduction of motive are inadmissible. The court left open whether such statements might be admissible under other rules of evidence.

"Sexual abuse suit dismissed" *Knoxville News-Sentinel*, January 7, 1995

An \$8 million lawsuit brought by two daughters of an Oak Ridge physicist has been dismissed. The daughters alleged that the father sexually abused them "on many and frequent occasions during their childhood," and they repressed the memories. The women began recalling the events after they started undergoing therapy in 1989. The complaint was dismissed after a pretrial conference when attorneys for the daughters were asked to provide evidence concerning the validity of repressed memory claims.

Judge Kills Nun's Sex Suit, Stuart Vincent, *Newsday*, January 11, 1995

A \$3.75 million civil suit filed by a Long Island nun who said she was sexually abused by her mother superior more than 25 years ago has been dismissed because the statute of limitations for bringing that charge expired. In November, State Supreme Court Justice Alfred S. Robbins noted that "New York law does not recognize psychological trauma or repression as justification for avoiding the statute of limitations." Even if the statute has been extended to the maximum 10 years allowed by law under an insanity disorder, it was still filed more than 14 years too late.

LEGAL CORNER

FMSF Staff

"Testimony Limit Set on Child Abuse;

The Supreme Court by a 5-4 vote complicated prosecution. It ruled out testimony after a certain point"

Aaron Epstein, *Philadelphia Inquirer*, January 11, 1995

The U.S. Supreme Court limited the admission of some out-of-court statements made by an accusing witness in

"Memories," Pat Grossmith, NH Union Leader,
December 27, 1994

A New Hampshire case that is getting national attention is *State v. Joel Hungerford* and *State v. John Morahan*. Two women entered therapy and recovered memories of being raped years earlier, one by her father and one by her junior high teacher. Both men were indicted. Hillsborough County Superior Court Judge William J. Groff stated that before either woman can testify at trial, the state must prove that "repressed memories" exist and that remembering them through therapy is generally accepted in psychology. The state must also show that once recovered, those memories are accurate.

The hearing for the admissibility of recovered memory evidence has been set for March 27, 1995. The experts for the state are Jon Conte, Ph.D., Bessel van der Kolk, MD, and Daniel Brown, MD. The experts for the defense are Elizabeth Loftus, Ph.D., Paul McHugh, M.D., James Hudson, M.D.

"Justices to hear repressed memory cases"

Detroit Legal News, January 11, 1995,
by Chris Parks

The Michigan Supreme Court is hearing two cases that involved repressed memories. One case has been brought by Marlene Lemmerman who claims that she had flashbacks in March of 1989 about being sexually abused as a child. She says that she took a picture of herself as a toddler and confronted her father Benjamin Fealk in a hospital room. She also claims that an aunt also physically and sexually abused her from age 3 to puberty. She says her mother physically abused her and should have known about the other abuse. When the case was first brought it was dismissed because of the statute of limitations but that decision was reversed by the Michigan Court of Appeals.

The second case was filed by a woman who sued her 84 year old father in 1993 over abuse that allegedly took place more than 40 years ago.

The Appeals court said corroborating evidence is not required under the rule allowing some suits over late-discovered injury. The court said the harm to a defendant sued on a stale claim must be balanced against the harm to a plaintiff denied compensation through litigation. The court also said repressed memory is a form of insanity which stops the statute of limitations from running.

Our justice system and the many fine agencies which protect our children must, in the future, be more careful when bringing charges. All too many times an innocent person will be locked away for years and then released when the child recants their original accusation.

Many times the evidence was incredibly flimsy and uncorroborated. This only results in discrediting the court system and the child protection agencies themselves.

Stephen Black, *Times-News*,
Hendersonville, NC
January 8, 1995

Price list for the booklet *Frequently Asked Questions*

Quantity	Price per Packet
1-4	\$1.00
5-9	\$0.90
10-19	\$0.80
20-49	\$0.65
50-100	\$0.60

FROM OUR READERS MAKE A DIFFERENCE

This is a column that will let you know what people are doing to counteract the harm done by FMS. Remember that three years ago FMSF didn't exist. A group of 50 or so people found each other and today we are over 15,000. Together we have made a difference. How did this happen?

January was FMS Month at a university library in Ontario, Canada. There was a special display of all the new books that relate to recovered memory therapy. Why don't you get a copy of the *New York Review of Books* from Nov 17, and Dec 1 1994 and take it to your local librarian to make sure that they carry these important books.

February will see a display of FMS books and articles in the Main Branch of the Santa Cruz, California Public Library. This came about because some concerned people approached the library and asked to have the new books about FMS featured.

Dozens of families have written to say they have purchased some of these new books and presented them as gifts to their local libraries.

In December, the Illinois FMS Society arranged to have the FMSF Executive Director make a presentation to the North Shore Senior meeting in Northfield, IL. In addition to the 75 Seniors attending, Robert Kriz who heads the Chicago office of the Illinois Department of Licensing and Regulation was present to get information. Once again, when the meeting was concluded a few people identified themselves as being touched by FMS and asked for more information. Every time this happens, we suspect that we see just the tip of this iceberg.

You can make a difference. Please send me any ideas that you have had that were or might be successful so that we can tell others. Write to Katie Spanuello c/o FMSF.

EMDR, Who invented it?

Answer:.. My mother, that's who!!!!!!!!!!!!!!

By quickly waving her right index finger to and fro before our faces she resolved most problem behavior and restored the unhappy situation very quickly. Once again peace and harmony reigned until the next time.

RETRACTORS' CORNER

There are so many things to write about when you are a retractor. So many feelings to express, so many important aspects of Repressed Memory Therapy that you can share. The hurts, the frustration, the confusion, the embarrassment, not to mention the public humiliation. You may be asking yourself, "Why would anyone want to share these most personal aspects of their lives?" I can answer that very easily: it's an obligation I feel called to do. As an individual that experienced repressed memory therapy and its "finest," I can help others understand what did happen to them, what may be happening to them, what could happen to them, and hopefully, in some small way help parents, relatives, friends, co-workers and the general public understand what it is like inside somebody's mind when they are going through this treatment, and what it is like coming out of it.

Sometimes it feels so overwhelming as to where and how to start that it would be easier for me to do nothing. But, in doing nothing, I feel I would be contributing to the continued decay of human lives and the destruction of families. Recently, someone told me I had the ability to see the mental health profession in an objective manner, that even after having experienced this treatment, I didn't view therapy or therapists in a black or white manner. This really got me to thinking about how my family, friends, and even myself became very untrusting toward the profession as a whole. We all experienced trauma, pain, and loss. We have a right to be opinionated, to say the least, toward therapists and therapy. For some reason, I was not hardened to the profession as a whole. Perhaps it's because I have a degree in social work and believe in the value of being able to sort through situations in life. Perhaps it is because when I was at my worst, it was necessary for me to begin seeing a new therapist and doctor. At the time it felt like the worst possible thing that could happen, but, little did I know that change would help capture me from further destruction. Two extremely ethical doctors and a social worker helped redirect me to a path of independence, security, and self respect.

I feel that this experience leaves me with an obligation to express my belief that all therapy is not bad, nor are all therapists. I feel very strongly about this because in hating this medical specialty, people may chose to avoid getting help they could benefit from. It's natural, especially when what has happened has been a form of abuse, and for some, even a mental torture, under the direction of well respected, professional individuals. So, like any abused or frightened person we learn to mistrust the people we thought were the safest people to talk to.

There are many individuals who believe retractors and the FMSF hate all psychiatrists, psychologists, social workers, and therapists. I have not found this to be the case. One of the most gratifying things I have seen in a long time happened at the Memory and Reality conference in Baltimore. In a round table I had the opportunity to speak at, a psychiatrist apologized for her profession. Nearly in tears, she commented to retractors and families her sincere sorrow and anger at what has occurred in the therapy profession. She didn't offer excuses nor did she ask us to forgive. There

were many other professionals who expressed the same sentiment throughout the weekend. For me, wounds began healing upon hearing this. My faith in the profession was definitely coming back. Really, retractors who have endured this therapy are similar to individuals who have been physically and sexually abused. We feel the same way toward the people who hurt us. These professionals should be held accountable for their actions just as other abusers are responsible for their behaviors. But, to say all therapists are bad is simply not true. I have the proof, two doctors and a social worker who helped me regain my strength, my ability to bring back control to my mind, and the belief I need not be dependent on therapists.

It is my sincere desire that my thoughts may help others to see both sides. I do not expect everyone to see things as I do and it is certainly not my intention to convince hurt people to trust people they have no desire to trust. I do want everyone to be careful. People need to set their own agendas and boundaries in therapy. People should not assume that what others believe is necessarily the truth. With that in mind, if you feel the need to talk to someone, there are mental health professionals who are safe to consult.

A Retractor

JEAN'S STORY

I started seeing a therapist in October of 1990 due to post traumatic stress syndrome - caused by being raped three times by an ex-financee - in a period of two years. After a period of about nine to ten months, my therapist and my psychiatrist made the suggestion that I be hospitalized for a period of four weeks. From the time of admission on, everyone at the hospital seemed like zombies (mechanical robots). I had to wait until 10:30 p.m. to see my therapist. I was so tired of waiting for him that I didn't want to see him at all. From then on, he would show up at various times of the day and I would see my psychiatrist every day - usually during group sessions. My ex-psychiatrist is the one who started putting the abuse issues into my mind. And then, it was my therapist - sometimes in the consultation room at the hospital. With my written consent, my therapist and my psychiatrist arranged for me to undergo sodium amytal. I had to write out 10 questions and submit copies to my therapist and my psychiatrist two days before I underwent it. The test revealed that I had been abused by my father. I only got to hear part of the tape before I was led to confront my father on the abuse charges. As far as I know, that tape is nowhere to be found - it's lost for good.

Little did I know then that my dad never did abuse me. It almost split my parent's marriage of 32 years apart and destroyed the close relationship that my dad and I had. I am presently seeing another therapist who has helped me face a lot of the issues. I did not realize that my memories were false ones until a few months ago when a friend of mine had the same problems with the hospital and her therapist as well.

I am in the process of suing: the hospital, my ex-therapist, and my ex-psychiatrist for all of the damages they have done in my life. I am an FMS survivor and I hope and pray

that my story will help others out there who were tricked into believing that they were abused by their fathers and also were abused by their therapists and psychiatrists as well.

To all members of F.M.S.F.
December 17, 1994

It has been a unique experience for us, this "house arrest", but the incredible ability of the human mind and body to adjust to changing situations is just beyond imagination. We do very well day by day with the support of our family, friends and so many members of FMSF who have become our friends through the mail and telephone. The outpouring of love and support has carried us through to this point. We are so blessed by this and we are so very grateful.

We have been given advice, very good advice, by so many and have taken it seriously. We keep our minds and our hands busy. While we feel sorrow and heartbreak as many others do we have found that time has been a healer. Our thoughts are projected more outwardly to others and by doing this our own burden is lighter.

We look forward to a date for appeal which will most likely be late spring or early summer. Our attorneys have worked very hard for us and we pray for a successful outcome. Time is on our side.

With warmest regards,
Shirley & Ray Souza
Massachusetts

The Souzas have been under house arrest for more than a year and a half. The problem started after one of their daughters had a dream that she had been abused and extended to concern for her own children. Ray and Shirley's grandchildren were taken to child abuse professionals. Later, Ray and Shirley were accused of abuse including keeping the grandchildren in a cage in the basement and making them drink a green potion. The accusations became the basis of a criminal trial in which the Souzas were found guilty.

Teacher, is that for the test...?

It is mid-term week in a suburban high school. Short school days allow for long afternoons to prepare for the next examination. Like many other teenagers, he will nap a little, lose himself in the music resonating from his boom box, take a trip to the refrigerator, and study in between.

"What are you studying for?" I asked. "Health. I have health and French tomorrow," he replied. "What about in health," I asked neglecting French as a foreign tongue to me. "I have to memorize this list," he points to The Incest Survivors' Aftereffects Checklist handout. A plain copy of thirty-four items without reference. "Why in the world would anybody want to memorize this list? What are you studying in health, anyway?" I asked in horror. "Nobody wants to memorize this list, mother. It's going to be on the

test. We'll have to answer "True" or "False" to items on the list," he elaborated.

In the context of issues in childhood abuse, high school sophomores were given a five-piece handout sorting "fact" from "myth". The Child Abuse Fact Sheet had ten "facts" listed (i.e., every perpetrator was once a victim; children rarely invent stories of abuse). The Incest Survivors' Aftereffects Checklist provides "Alienation from the body—not at home in own body....wearing a lot of clothing, even in summer."

I was alarmed. As a mother, I asked how many teenage girls feel at home in their bodies? I thought of the possibility of a teenage girl diligently memorizing the checklist reading, "Do you find many characteristics of yourself on this list? If so, you could be a survivor of incest." She could become unnecessarily anxious thinking that some of the items do apply to her. And item 26: "Denial: No awareness at all; repression of memories...." Could it be?

But I was even more alarmed as a science educator. I was shaken at a very basic level of my understanding of what constitutes academic integrity. The use of term fact to denote ideas that are controversial at best, while by definition a fact has to be agreed upon by all observers, was particularly disturbing, serving as an example of so much that is wrong in science education. I referred to the National Science Education Standards (November, 1994), a serious attempt to provide a vision of learning and teaching science. Here is one item on the list of abilities of scientific inquiry, "Scientific explanations must adhere to criteria such as: a proposed explanation must have a logical structure; it must abide by the rules of evidence; it must be open to questions and possible modifications; it must be based on historical and current scientific knowledge; and the methods and procedures scientists used to obtain evidence must be adequately reported to enhance opportunities for further investigation."

Teachers are called upon to engage students in conversations that focus on questions such as:

How do you know?

How certain are you of those results?

Is there an alternative scientific explanation for the one we proposed?

Do we need more evidence?

How do you account for an explanation that is different from ours?

The act of providing students with this checklist—no source, no evidence, no alternative explanations, no questions—violates every aspect of science education. This incident may be local. It may be an isolated event of poor educational judgment. But it may not be.

Mother and Teacher

DESTINATION UNKNOWN

A few years ago our adult daughter became deeply involved in "memory retrieval therapy" also known as the "recovery movement." Knowing that we are powerless to

Memory and Reality: Emerging Crisis

Video inspired by FMSF Valley Forge Conference in April, 1993

**What is memory? What is false memory syndrome? Can memories be repressed?
Can memories be recovered through the use of "therapeutic techniques?"**

All of these questions are addressed in an important and special video presentation,
Memory and Reality: Emerging Crisis.

This remarkable videotape presentation brings together prominent memory researchers and mental health professionals who scrutinize these questions, and bring to the discussion of repressed memories vs. false memory syndrome, all of their experience, intelligence, and expertise. These most highly qualified professionals share their research and their knowledge, and explore the important and critical subject of **memory: What it is and what it is not.** This video features:

Elizabeth F. Loftus, Ph.D., Richard A. Gardner, MD, Steven M. Garver, Esq., Harold I. Lief, MD, Campbell Perry, Ph.D., Martin E.P. Seligman, Ph.D., Paul R. McHugh, MD., Judge Lisa A. Richette., Michael D. Yapko, Ph.D., David F. Dinges, Ph.D., Richard J. Ofshe., Ph.D., George K. Ganaway, MD., Margaret T. Signer, Ph.D., Melody Gavigan, retractor.

Gemini Productions, Inc. is pleased to offer this exceptional videotape, *Memory and Reality: Emerging Crisis*, at the special rate of \$69.50 (including postage and handling). A complete transcript of the videotape is also available for \$15.00. To order or for more information, contact:

Gemini Productions, Inc., 18630 Detroit Ave., Lakewood, OH 44107
Phone (216) 228-9440 Fax (216) 228-8024

help her, our family has come to reluctantly accept what has happened to her. Our daughter still does not perceive the consequences of her misplaced trust, her involvement, or her subsequent transformation of thought and personality.

Ever since we learned of her dilemma I have lamented all that she has lost during her tenure as a "survivor" for she has lost so much. Recently, however, I have come to the realization that she really hasn't lost anything. With a lot of help from others, she has purposefully and systematically thrown it all away.

In truth, she has thrown away her entire immediate and extended family, her former friends, and all the nurturing and reinforcement, the ups and downs that come with having those people in one's life. She has thrown away her bona fide history and has replaced it with frightening script, horrific scenarios, and a false yet horrifying drama of early childhood abuse. All this is based upon an unscientific, unproven theory of "repression," upon the hypnotic persuasion of a person who calls himself a "therapist," and upon the suggestion and manipulation of other true believers ensnared by his movement.

She has thrown away joyous holidays, presents, happy feasts, surprises, and the celebration of life and living. She has thrown away happy times, sad times, in-between times, and the continuity of life in the unique, protective, caring environment of her childhood home. By opting for hatred, cruelty, and revenge, she has forsaken her roots and poisoned the ground in which they grew.

It is extremely frightening to know that she has thrown

away reality and has replaced it with confabulation, delusion, paranoia, hysteria, and zeal. She has thrown away good mental health and sound emotional balance. She has adopted a new and different mindset, personality, and persona and has adapted to and become frozen in those new entities. She has thrown away her True Self and we wonder if she will ever be able to recapture that Self or recover.

Most sadly of all, she has thrown away LOVE, that most precious of all life's gifts. Once she was blessed with abundant, unconditional love -- a love which, in effect, said:

"No matter what you do or say, we will always love you. We will always be there to stand by you, to pick you up when you fall, to cheer you, to praise you, to comfort you and give you strength through stormy days, through illness, or times of heartache and sorrow." This, too she has chosen to turn her back on. She has thrown away, discarded, rejected, renounced our love.

So many, many things are gone now. . . Thrown away by a person who has chosen to become an island unto herself—a Victim, a Hero, a Martyr. She has opted to become separated from all former things. She has literally become an orphan—a most lamentable stranger traveling alone on the precarious road of life. Where is she going? Who will be there waiting to embrace her when she arrives at her journey's end? What will she have gained and who will she become by the time her sojourn is over?

Perhaps it is better not to contemplate these questions. Perhaps, just for now, it is better not to think about it all . . .

Letters in response to the questions about PAIMI (Protection and Advocacy for Individuals with Mental Illness)

From a Clinician

"I use an abbreviated form of the Mental Health Bill of Rights as a part of my regular intake and evaluation. Except for the specific reference to experimental treatments, the points covered are those that would apply in an outpatient setting. I consider it an important facet of the informed consent process."

From California

"The Mental Health Bill of Rights came about as a result of abuse in the mental health care system. California law requires mental health hospitals to give patients a Bill of Rights, but a therapist in his or her office is not required to do this. Good clinics give the patient the Bill of Rights to keep because the Mental Health Bill of Rights may not be fully understood by patients who are depressed, confused or anxious."

From Delaware

Althea McDowell, Esq of the Disabilities Law Program at the Community Legal Aid Society, Inc wrote to one of the families in Delaware that "The Disabilities Law Program (commonly referred to as the DLP), provides services to individuals under the Protection and Advocacy for Individuals with Mental Illness Act (commonly referred to as the PAIMI Act).

Mental Health Bill of Rights

- the right to an individualized, written treatment plan, providing for periodic reassessment and revision;
- the right to know the objectives of a treatment, the possible adverse effects of treatment, and any available alternative treatments, services and providers;
- the right not to receive a mode or course of treatment in the absence of informed, voluntary and written consent;
- the right not to participate in experimentation in the absence of informed, voluntary, written consent;
- the right to appropriate protections in connection with one's participation in an experimental treatment, including the right to a reasonable explanation of the procedure to be followed, the benefits to be expected, the relative advantages of alternative treatments, and the potential discomforts and risks;
- the right and opportunity to revoke one's consent to an experimental treatment;
- the right to freedom from restraint or seclusion;
- the right of a patient in a treatment facility to converse with others privately and to see visitors during regularly scheduled hours; if a treating professional denies access to a particular visitor, it must be for a specific, limited, and reasonable period of time, the denial must be incorporated into the written treatment plan and must include the reasons for such denial;
- the right, upon admission to a treatment facility, to be informed of the rights set forth above.

From a letter to a parent from State of New York Department of Health

I can understand your concern considering the sensitive nature of this subject [memory retrieval] compounded by the potential for devastation of families. This issue is very controversial. To date, there is no legislation or standards of care in place. It is therefore impossible to prove violations were committed.

ensure that the rights of individuals with mental illness are protected through advocacy activities to enforce the Constitution and federal and state statutes and laws.

Client eligibility under the PAIMI Act, however, does not extend to everyone who has a mental illness. The individual must have a mental illness and reside in a public or private residential setting and have a legal problem that arises while residing in such setting or within 90 days of discharge from that setting. Residential settings include hospitals, nursing homes, institutions, community care homes, and prisons. The Complainant may simply be a person who is concerned regarding a person who falls within these guidelines."

More from Delaware

PAIMI information booklets are available for each person as they enter the state run mental health facilities. It is not certain that the materials stating the Bill of Rights of patients actually get into the hands of the patients, however.

The resources available through PAIMI are not well-known. Here are some suggestions to make it and the Mental Health Bill of Rights more effective:

1. Educate lawyers. Now many lawyers do not know about the existence of PAIMI.
2. Educate the public. Many are unaware of the potential help from PAIMI.

The general mission of the PAIMI Program is to

FEBRUARY 1995 FMSF MEETINGS

FAMILIES, RETRACTORS & PROFESSIONALS
WORKING TOGETHER

STATE MEETINGS

INDIANA

INDIANAPOLIS

Sunday, April 23, 1:00 - 4:30 pm
Nickie (317) 471-0922 (phone); 334-9839 (fax)
Gene (317) 861-4720 or 861-5832

PENNSYLVANIA, NEW JERSEY, DELAWARE

Saturday, March 25, 1995, 10:00 am - 5:00 pm
Sheraton Convention Center
KING OF PRUSSIA, PA
Call Jim & JoAnne (610) 783-0396

UNITED STATES

Call person listed for meeting time & location.
key: (MO) = monthly; (bi-MO) = bi-monthly

ARKANSAS - AREA CODE 501

LITTLE ROCK
Al & Lela 363-4368

CALIFORNIA

NORTHERN CALIFORNIA

SACRAMENTO/CENTRAL VALLEY - BI-MONTHLY
Charles & Mary Kay (916) 961-8257

SAN FRANCISCO & BAY AREA - BI-MONTHLY

EAST BAY AREA
Judy (510) 254-2605

SAN FRANCISCO & NORTH BAY

Gideon (415) 389-0254
Charles (415) 984-6626 (day); 435-9618 (eve)

SOUTH BAY AREA

Jack & Pat (408) 425-1430
Last Saturday, (Bi-MO)

CENTRAL COAST

Carole (805) 967-8058

SOUTHERN CALIFORNIA

BURBANK (formerly VALENCIA)

Jane & Mark (805) 947-4376
4th Saturday (MO) 10:00 am

CENTRAL ORANGE COUNTY

Chris & Alan (714) 733-2925
1st Friday (MO) - 7:00 pm

ORANGE COUNTY (formerly LAGUNA BEACH)

Jerry & Eileen (714) 494-9704
3rd Sunday (MO) - 6:00 pm

COVINA GROUP (formerly RANCHO CUCAMONGA)

Floyd & Libby (818) 330-2321
1st Monday, (MO) - 7:30 pm

WEST ORANGE COUNTY

Carole (310) 596-8048
2nd Saturday (MO)

COLORADO

DENVER

Ruth (303) 757-3622
4th Saturday, (MO) 1:00 pm

CONNECTICUT - AREA CODE 203

NEW HAVEN AREA

George 243-2740

FLORIDA

DADE-BROWARD AREA

Madeline (305) 986-4FMS

DELRAY BEACH PRT

Esther (407) 364-8290
2nd & 4th Thursday (MO) 1:00 pm

TAMPA BAY AREA

Bob & Janet (813) 856-7091

ILLINOIS

CHICAGO METRO AREA (South of the Eisenhower)

2nd Sunday (MO) 2:00 pm
Roger (708) 366-3717

INDIANA

INDIANAPOLIS AREA

Nickie (317) 471-0922 (phone); 334-9839 (fax)
Gene (317) 861-4720 or 861-5832
SEE STATE MEETINGS NOTICE

IOWA

DES MOINES

Betty/Gayle (515) 270-6976
2nd Saturday (MO) 11:30 am Lunch

KANSAS

KANSAS CITY

Pat (913) 738-4840
Jan (816) 931-1340
2nd Sunday (MO)

KENTUCKY

LEXINGTON

Dixie (606) 356-9309

LOUISVILLE

Bob (502) 957-2378
Last Sunday (MO) 2:00 pm

MAINE - AREA CODE 207

BANGOR

Irvine & Arlene 942-8473

FREEMPORT

Wally 865-4044
3rd Sunday (MO)

YARMOUTH

Betsy 846-4268

MARYLAND

ELLCOT CITY AREA

Margie (410) 750-8694

MASSACHUSETTS / NEW ENGLAND

CHELMSFORD

Jean (508) 250-1055

MICHIGAN

GRAND RAPIDS AREA - JENISON

Catharine (616) 363-1354
2nd Monday (MO)

MINNESOTA

ST. PAUL

Terry & Collette (507) 642-3630

MISSOURI

KANSAS CITY

Pat (913) 738-4840
Jan (816) 931-1340
2nd Sunday (MO)

ST. LOUIS AREA

Karen (314) 432-8789
Mae (314) 837-1976
3rd Sunday (MO) 1:30 pm
Retractors support group also meeting.

SPRINGFIELD - AREA CODES 417 AND 501

Dorothy & Pete (417) 882-1821
Nancy & John (417) 883-4873
4th Sunday (MO) 5:30 pm

NEW JERSEY (So.) See PENNSYLVANIA (WAYNE)

NEW YORK

DOWNSTATE NY - WESTCHESTER, ROCKLAND & OTHERS

Barbara (914) 761-3627 - call for meeting info
4th Sunday, March 26, 1995 in lower Connecticut

UPSTATE / ALBANY AREA

Elaine (518) 399-5749

WESTERN / ROCHESTER AREA

George & Eileen (716) 586-7942
March 12, 1995 - 1:15 pm

OHIO

CINCINNATI

Bob (513) 541-5272
2nd Sunday (MO) 2:00-4:30 pm

OKLAHOMA - AREA CODE 405

OKLAHOMA CITY

Len 364-4063 Dee 942-0531
HJ 755-3816 Rosemary 439-2459

PENNSYLVANIA

HARRISBURG AREA

Paul & Betty (717) 691-7660

PITTSBURGH

Rick & Renee (412) 563-5616
WAYNE (includes So. Jersey)
Jim & Joanne (610) 783-0396
SEE STATE MEETINGS NOTICE

TENNESSEE

MIDDLE TENNESSEE

Kate (615) 665-1160
1st Tuesday (MO) 1:00 pm

TEXAS

CENTRAL TEXAS

Nancy & Jim (512) 478-8395

DALLAS/FT. WORTH

Lee & Jean (214) 279-0250

HOUSTON

Jo or Beverly (713) 464-8970

VERMONT & UPSTATE NEW YORK

Elaine (518) 399-5749

WISCONSIN

Katie & Leo (414) 476-0285

CANADA

BRITISH COLUMBIA

VANCOUVER & MAINLAND

Ruth (604) 925-1539
Last Saturday (MO) 1:00-4:00 pm

VICTORIA & VANCOUVER ISLAND

John (604) 721-3219
3rd Tuesday (MO) 7:30 pm

MANITOBA

WINNIPEG

Muriel (204) 261-0212
1st Sunday (MO)

ONTARIO

OTTAWA

Eileen (613) 836-3294

TORONTO - NORTH YORK

Pat (416) 444-9078
Saturday, February 18 (Bi-MO) 1-3 pm
Studio 4, Civic Garden Ctr, 777 Lawrence St-East

ANNUAL MEETING - TORONTO, ONTARIO

Saturday, April 22, 1995, 1-5 pm
Pat (416) 444-9078

AUSTRALIA

Ken & June, P O Box 363, Unley, SA 5061

NETHERLANDS

Task Force False Memory Syndrome of
"Ouders voor Kinderen"

Mrs. Anna de Jong, (0) 20-693 5692

NEW ZEALAND

Mrs. Colleen Waugh, (09) 416-7443

UNITED KINGDOM

The British False Memory Society
Roger Scotford (0225) 868-682

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Deadline for MARCH 1995 issue:

Friday, February 17th

Do you have access to e-mail? Send a message to
 pjf@cis.upenn.edu
 if you wish to receive electronic versions of this
 newsletter and notices of radio and television broad-
 casts about FMS. All the message need say is "add
 to the FMS list". It would be useful, but not neces-
 sary, if you add your full name (all addresses and
 names will remain strictly confidential).

FMS Foundation

3401 Market Street, Suite 130 Philadelphia, PA 19104-3315

Phone 215-387-1865

ISSN # 1069-0484

Pamela Freyd, Ph.D., Executive Director

FMSF Scientific and Professional Advisory Board

February 1, 1995

The False Memory Syndrome Foundation is a qualified 501(c)(3) corporation with its principal offices in Philadelphia and governed by its Board of Directors. While it encourages participation by its members in its activities, it must be understood that the Foundation has no affiliates and that no other organization or person is authorized to speak for the Foundation without the prior written approval of the Executive Director. All membership dues and contributions to the Foundation must be forwarded to the Foundation for its disposition.

The FMSF Newsletter is published 10 times a year by the False Memory Syndrome Foundation. A subscription is included in membership fees. Others may subscribe by sending a check or money order, payable to FMS Foundation, to the address below. 1995 subscription rates: USA: 1 year \$30, Student \$10; Canada: 1 year \$35 (in U.S. dollars); Foreign: 1 year \$40. (Single issue price: \$3 plus postage.

What IF?

What if, parents who are facing lawsuits and want legal information about FMS cases, had to be told, "I'm sorry, there isn't any such thing available?"

What if, your son or daughter began to doubt his or her memories and called FMSF only to get a recording, "This number is no longer in operation?"

What if, a journalist asks you where to get information about the FMS phenomenon, and you had to answer, "Sorry, I don't know?"

What if, you want to ask a question that only an expert, familiar with FMS can answer, and find out that FMSF can no longer provide that information? Where would you turn?

What if the False Memory Syndrome Foundation did not exist? A frightening thought, isn't it?

Please support our Foundation. We cannot survive without your support!

Reprinted from the August 1994 PFA (MI) Newsletter

YEARLY FMSF MEMBERSHIP INFORMATION

Professional - Includes Newsletter \$125 _____

Family - Includes Newsletter \$100 _____

Additional Contribution: _____

Visa: Card # & expiration date: _____

Mastercard: Card # & expiration date: _____

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